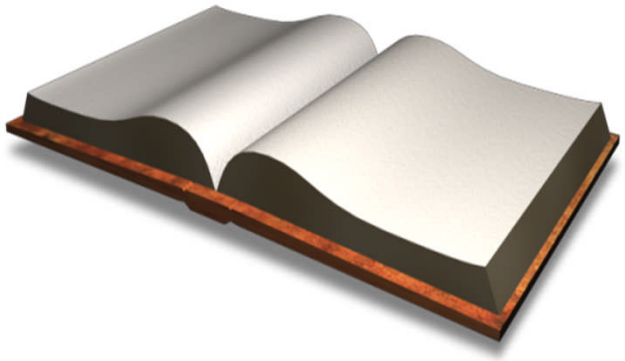
Documentation Policy (104.09) and Organizational Providers Manual, Chapter 1&2 Changes

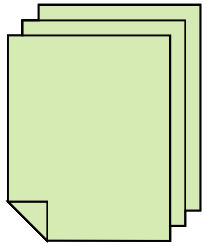


Program Support Bureau
Quality Assurance Division
August 25, 2014

Purpose

- Describe the new and updated sections in the Organizational Provider's Manual, Chapters 1 & 2.
- Highlight areas in the Org Manual that have been changed significantly.
- Briefly describe the minimum documentation standards for the County of Los Angeles, Department of Mental Health.
- Describe each type of new assessment, its required data elements, and the circumstances in which it is used.
- Identify the changes to the Client Treatment Plan.
- List the reimbursable service components under each type of service (MHS, MSS, TCM, and CI)

Handouts for Today



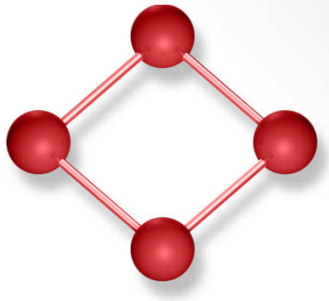
- Material for today includes:
  - Powerpoint
  - Chapters 1 and 2 of the Org Manual
  - Policy 104.09
  - What's New
  - Types of Services
  - Scenario Examples

WHY DID WE MAKE CHANGES?

- **Recent changes to the Clinical Documentation Policy 104.09 were necessary due to:**
  - *Inception of IBHIS/Changes in episodes*
  - *Inception of the Affordable Healthcare Act (ACA)*
  - *Findings of the recent State Chart Review.*

- **The Organizational Providers Manual was revised to:**
  - *Reflect changes in 104.09 and QA Bulletins*
  - *Minimize redundancy between the two documents*
  - *Clarify topics that needed additional detail*

Structure of Training



- Will walk through each section of the Organizational Provider's Manual Chapters 1 and 2
- Will identify key 104.09 policy statements that link to the Org Manual
- Will expand on areas identified with the NEW icon

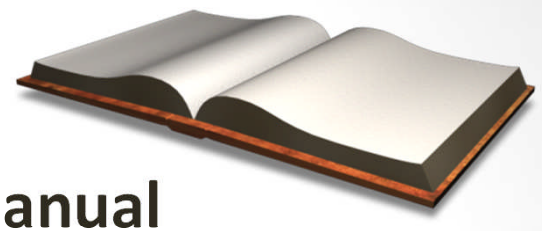
Chapter 1

Service, Documentation and Reimbursement Basics

GENERAL SERVICE AND REIMBURSEMENT RULES
MEDI-CAL MEDICAL NECESSITY – THE CLINICAL LOOP
ASSESSMENT NEW
CLIENT TREATMENT PLAN
PROGRESS NOTES NEW

HOPE WELLNESS RECOVERY
LAC DMH
LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

OVERVIEW



Short-Doyle Organizational Provider's Manual

- Reflects current requirements for direct services reimbursed by Medi-Cal
- Basis for all documentation and claiming in the Los Angeles County Department of Mental Health regardless of payer source (per LACDMH Policy).
- All providers, whether Directly-Operated or Contracted, must abide by the information found in this manual per LACDMH Policy 104.09.
- Updated version now available online
  - DO's can access through the DMH Intranet
    - DMH Websites Tab ➡ Program Support Bureau ➡ QA Division
  - LE's can access through the DMH Internet site
    - http://dmh.lacounty.gov ➡ For Providers ➡ Administrative Tools ➡ Provider Manuals and Directories.

Service Philosophy

Medi-Cal services provided under the Federal Rehab Option

- Focus on clients' needs, strengths, choices.
- Assist clients in making informed decisions.
- Based on clients' long term, recovery-oriented goals which should have **S**pecific, **M**easurable, **A**chievable, **R**ealistic and **T**ime-bound (SMART) objectives.
- Delivered by multi-disciplinary and multi-cultural staff.
- Provided by licensed and unlicensed mental health staff.
- Encourage involvement of significant support persons

(Org. Manual Pg. 6)

General Services & Reimbursement Rules

As we go through these guidelines and rules for reimbursement, please keep the following in mind:

- These are **minimum** requirements by the state.
- You/your agency can always do more.
- Just because it's a minimum requirement doesn't mean it's the best clinical practice.

General Services & Reimbursement Rules

Medi-Cal Reimbursement Rules

- Key Points Applicable to One or More Modes of Service (e.g. Mode 5,10, 15)
  - Compliance with licensing requirements
  - Each claim must be supported by a progress note
  - Services must be provided under direction of an **Authorized Mental Health Discipline (AMHD)**.
  - Services must be provided within scope of practice
  - Services provided after death not claimable under Med-Cal. Check with agency for other funding sources.
  - Notes must be legible

(Org. Manual Ch.1, pgs. 6-7)

General Services & Reimbursement Rules

- **Cont'd Key Points Applicable to Modes of Service**
  - Documentation & travel time must link to reimbursable services

***Note:** The department is working to get more information from the state on travel time.

General Service and Reimbursement Rules

General Documentation Rules

- Must Adhere to LACDMH Policy 104.08 & 104.09
- Directly Operated Providers must use DMH approved forms or IBHIS.
- Contractors must incorporate all LACDMH required documentation elements.
- Must document special client needs and accommodations made to address those needs.
- NEW Signatures of the person providing the service, type of professional degree, licensure, or job title, and the relevant certification number (if applicable).
- Co-signer takes responsibility and liability for service.

(Org. Manual, pgs. 10-11)

Cultural Competency

- Culture is the integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values.
  - Includes institutions of a racial, ethnic, religious or social group.
  - Considers socioeconomic class, disabilities, religious/spiritual beliefs and sexual orientation. [*U.S. Department of Health and Human Services, Office of Minority Health (2013). The National Culturally and Linguistically Appropriate Services(CLAS Standards*)]

(Org. Manual pg.10)

MEDI-CAL MEDICAL NECESSITY

- Treatment services which may be justified
- Term used by third party payer criteria
- Includes included diagnosis (per DSM IV), impairments and interventions
- 

Does not mean every Progress Note needs to document **all** elements of medical necessity

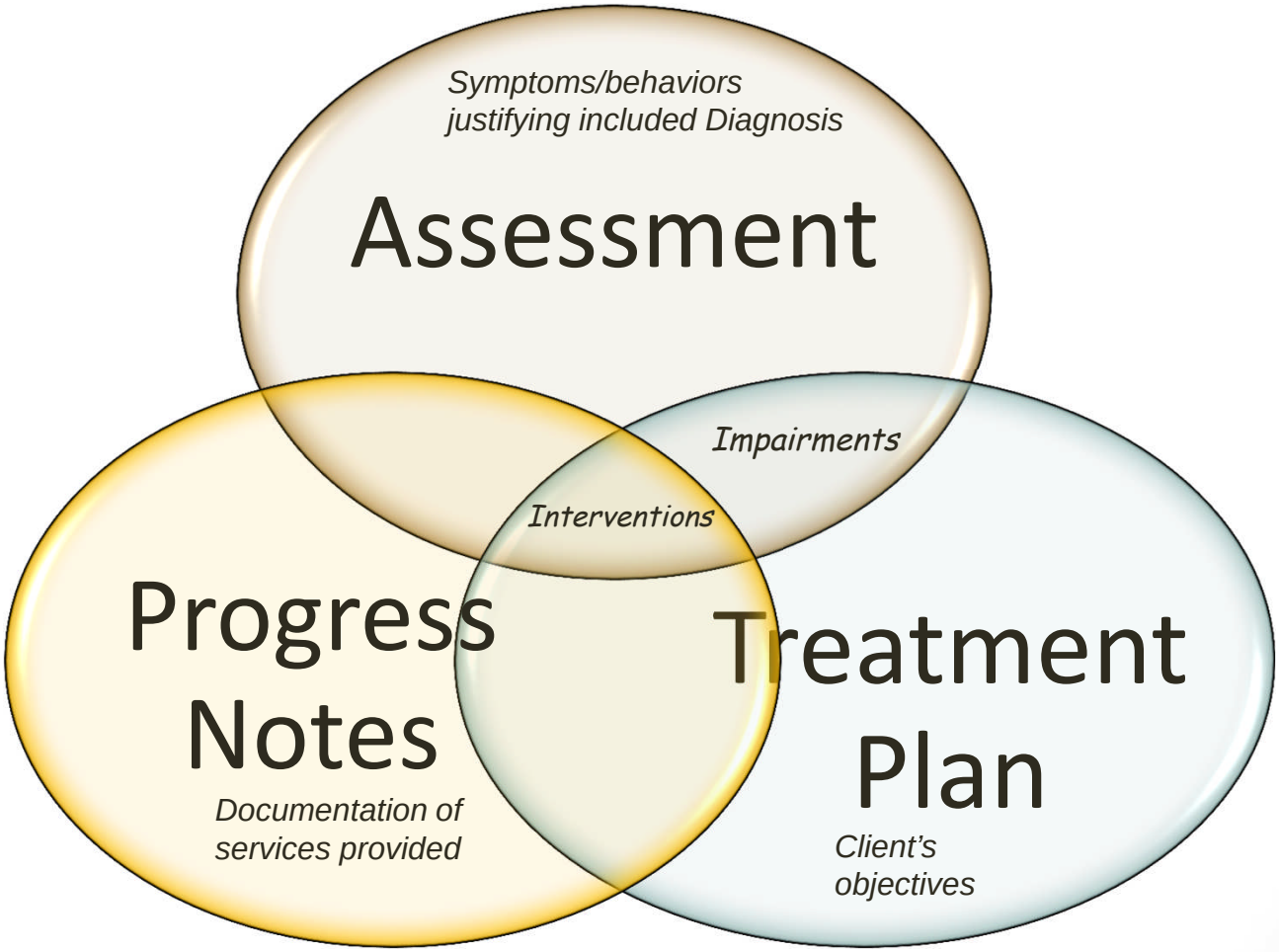
(Org. Manual, pg. 11-13)

THE CLINICAL LOOP

- **Definition**: Sequence of documentation that supports medical necessity for the purpose of reimbursement.
  - **Sequence of Documentation:**
    - **Assessment -**Documents symptoms and behaviors to formulate a diagnosis, impairments, needs and strengths.
    - **Client Treatment Plan –** Goals/objectives/interventions that link back to symptoms/behaviors/impairments identified in the assessment.
    - **Progress Notes -** Documents all services provided which relate back to the interventions identified in the Client Treatment Plan.

(Org Manual, pgs.13-14)

THE CLINICAL LOOP



Policy 104.09: Assessment

"A new assessment is required in the clinical record within 60 days of initiation of any services related to assessment or treatment for all newly active clients and must clearly document all assessment elements as identified in the Organizational Provider's Manual."

(LACDMH Policy 104.09 , section 4.1)

Policy 104.09: Assessment

Newly Active Client:

A new client requiring the opening of a new clinical record

OR

An existing client returning for services due to a new or resurfacing presenting problem after the termination of services per LACDMH Policy 202.30 (Mutual & Unilateral Termination of Mental Health Services)

OR

An existing client returning for services after 180+ days of inactivity

(LACDMH Policy 202.30, Section 2.9)

Policy 104.09: Assessment

"For active clients, an assessment is required when there is a significant change in clinical information or, at a minimum, every three years."

(LACDMH Policy 104.09 , section 4.3)

ASSESSMENT

- Policy 104.09:
  - Simply refers to the requirement for an “assessment”

- Organizational Providers Manual:
  - Operationalizes the requirements in 104.09
  - Describes the different types of assessments, requirements, data elements and forms

ASSESSMENT

- **Purpose**
  - Understand the client's history/background
  - Get a sense of inter-relationship between symptom/behavior and client as a whole person
  - Foundation for client & staff to develop agreed upon plan of treatment and recovery
  - See 104.09 Policy Handout

- **Assessments Must be Completed for**:
  - **New Clients (Newly Active)** –Require opening of a new clinical record
  - **Returning Clients (Newly Active)-** Existing client returning for services after 180 days or more of inactivity or client who has been terminated (per policy 202.30)

  - **Continuous Clients** – Existing client who has not had treatment terminated per Policy 202.30.

(Org. Manual, pgs. 14-19)

Assessment – New Client

- **Assessments for New Clients**
  - Assessment for clients requiring the creation of a clinical record must be completed within 60 days of the initiation of services
  - Any program accepting a client is responsible for ensuring there is a current, complete and accurate assessment
- **Forms/Data Elements (**Only one full assessment is required in the clinical record**)**
  - Paper form- Adult Full Assessment (MH 532), Child/Adolescent Full Assessment (MH 533), ICARE (for 0 – 5) Initial Assessment (MH 645)
  - IBHIS- Adult Full Assessment Bundle, Child/Adolescent Full Assessment Bundle, Age 0 – 5 ICARE Full Assessment
  - Contractor with EHR- Data elements identified in the Org Manual
  - **See pgs. 15 – 17 of Org Manual for complete list of elements of assessment.**
- **New Sections of Assessment**
  - History of Trauma or Exposure to Trauma
  - Specialty Mental Health Medical Necessity Criteria

See **What's New handout for further information about changes to the assessments for new clients.

(Org. Manual pgs. 15-17 for required elements)

ASSESSMENT – RETURNING CLIENT

- **Assessments for Returning Client**
  - **Assessments for returning clients (**Clients returning for services after termination of services or 180 days of inactivity and NOT requiring a new Clinical Record) must be completed within 60 days of the initiation of services related to assessment or treatment
  - Any program accepting a client is responsible for ensuring there is a current, complete and accurate assessment
- **Forms/Data Elements**
  - Paper form - Adult Re-Assessment (MH 713), Child/Adolescent Re-Assessment (MH 714)
  - IBHIS- Adult Assessment Addendum Bundle, Child/Adolescent Assessment Addendum Bundle
  - Contract with EHR- Data elements identified in the Org Manual
  - **See pgs. 15 – 17 of Org Manual for complete list of elements of assessment.**

(Org. Manual pg. 18)

ASSESSMENT – CONTINUOUS CLIENTS

- **Assessment for Continuous Clients**
  - Assessments for continuous clients (clients who have not had treatment terminated per Policy 202.30 or 180 days of inactivity) must be completed every 3 years.
    - Most recent assessment in the client's record sets the 3 year time limit based on the start date of the assessment.
  - Any program treating a client for 3 continuous years is responsible for ensuring there is an assessment in the Clinical Record.

(Org. Manual pgs. 18-19)

ASSESSMENT – CONTINUOUS CLIENTS

- **Forms/Data Elements**
  - Paper form- Adult Re-Assessment (MH 713), Child/Adolescent Re-Assessment (MH 714)
  - IBHIS- Adult Assessment Addendum Bundle, Child/Adolescent Assessment Addendum Bundle
  - Contractor with EHR- Data elements identified in the Org Manual
  - **See pgs. 15 – 17 of Org Manual for complete list of elements of assessment.**
- **Continuous Client Assessment Requirements:**
  - Same data elements as the assessment for returning clients.
    - Does not include precipitating events/reason for referral
  - Need to include Updates/Changes to:
    - Mental Health History including psychiatric hospitalizations and outpatient treatment , medications, substance use, medical, psychosocial history including education, employment, legal, current living arrangements and social supports, dependent care issues and family/relationships.
    - Developmental History (for children)

ASSESSMENT - ADDENDUM

- **Assessment Addendum**
  - Required when there is additional information gathered (change or addition) after the completion of a Full Assessment and prior to providing any services that are not justified by the current Assessment.

- **Assessment Addendum Forms**
  - Paper form- Adult Assessment Addendum (MH 532A), Child/Adolescent Addendum (MH 533A)
  - IBHIS- Adult Assessment Addendum, Child/Adolescent Assessment Addendum
  - Contractor with EHR- Form that encompasses the concept.

(Org. Manual pg. 19)

Assessment Forms

- **New Client**
  - Paper form- Adult Full Assessment (MH 532), Child/Adolescent Full Assessment (MH 533)
  - IBHIS- Adult Full Assessment Bundle, Child/Adolescent Full Assessment Bundle
  - Contractor with EHR- Data elements identified in the Org Manual
- **Returning Client**
  - Paper form - Adult Re-Assessment (MH 713), Child/Adolescent Re-Assessment (MH 714)
  - IBHIS- Adult Assessment Addendum Bundle, Child/Adolescent Assessment Addendum Bundle
  - Contract with EHR- Data elements identified in the Org Manual
- **Continuous Client**
  - Paper form- Adult Re-Assessment (MH 713), Child/Adolescent Re-Assessment (MH 714)
  - IBHIS- Adult Assessment Addendum Bundle, Child/Adolescent Assessment Addendum Bundle
  - Contractor with EHR- Data elements identified in the Org Manual
- **Assessment Addendum**
  - Paper form- Adult Assessment Addendum (MH 532A), Child/Adolescent Addendum (MH 533A)
  - IBHIS- Adult Assessment Addendum, Child/Adolescent Assessment Addendum
  - Contractor with EHR- Form that encompasses the concept.

*Note: For 0-5 clients, the ICARE MH 645 may be used

Policy 104.09: Client Treatment Plan

"A client treatment plan is required in the clinical record after the completion of a new assessment and prior to providing treatment services and must clearly document all client treatment plan elements as identified in the Organizational Provider's Manual. For newly active clients, the treatment plan is minimally required within 60 days of initiation of services, excluding crisis intervention"

(LACDMH Policy 104.09, section 4.4)

Policy 104.09: Client Treatment Plan

Treatment Services:

Services addressing client mental health concerns that are not primarily for the purpose of assessment, plan development, crisis intervention or, during the first 60 days for newly active clients, linkage to other mental health programs.

(LACDMH Policy 104.09, section 2.13)

Policy 104.09: Client Treatment Plan

"For active clients agreeing to continue services, a new client treatment plan must minimally be completed with the client at least once every 365 days. If the client is unavailable by the conclusion of the one year period, the client treatment plan must be completed at the point of the next service with the client"

(LACDMH Policy 104.09, section 4.4.1)

Client Treatment Plans

- **Policy 104.09:**
  - Simply refers to the requirement for a treatment plan

- **Organizational Providers Manual:**
  - Operationalizes the requirements in 104.09
  - Describes the different types of treatment plans, requirements, processes for treatment planning, data elements and forms

CLIENT TREATMENT PLAN

- **Client Treatment Plan should be:**
  - Individualized, strengths-based services; addresses linguistic and interpretive needs
  - A coordinated effort between **client**, mental health staff, and family (when appropriate).
  - Per best practice, occurring with the **client present** and there must be evidence of the **client's participation** in the treatment planning process. The **client's signature** on the Client Treatment Plan provides this evidence.
  - A tool to guide treatment.
  - Focused on client's goals and objectives.
  - 

Completed prior to providing treatment services

(Org. Manual, pg. 19 – 23)

CLIENT TREATMENT PLAN

Writing the Client Treatment Plan

- It is best practice for Client Treatment Plan objectives, and the proposed interventions supporting those objectives, to be written by an AMHD for whom the services are within scope of practice.
- When services are outside the scope of practice of the writer (whether or not they're an AMHD), the following guidelines must be adhered to:
  - a face-to face discussion must take place **prior** to the objectives/interventions being written, between the writer and the individual for whom the interventions are within scope of practice.
    - This discussion must be detailed enough to provide writer with clear direction on all important treatment related elements of the objectives/interventions.
    - The individual for whom the interventions are within scope of practice is responsible for content of the objectives/interventions that result from the face to face discussion.

(Org. Manual pg. 20)

CLIENT TREATMENT PLAN

The Client Treatment Plan is not final until signed/dated by the appropriate staff and client/responsible adult.

- **Required Staff Signatures**:
  - Authorized Mental Health Discipline (AMHD) (see General Documentation Rules).
  - Writer of the objective
  - For all Medication Support Service interventions, a staff person within scope of practice (LACDMH requirement)

- **Required Client/Responsible Adult Signatures:**
  - For all objectives, the client or a parent, Authorized Caregiver, Guardian, LPS Conservator, or personal representative for treatment.

****Note: Client of any age may sign (as appropriate)**

(Org. Manual pg. 23)

Client Treatment Plan

Treatment Plans without Client Signature

- When client is **unable** to sign due to their mental state (e.g., client is experiencing agitation or psychosis):
  - When the situation that made it difficult for the client to sign is resolved (e.g., psychotic symptoms diminish), as documented in the clinical record, another attempt must be made, and documented.

- When the client or other required participant is **unwilling** to sign the client treatment plan due to a disagreement with the plan:
  - Every reasonable effort should be made to adjust the plan in order to come to an agreement with the client or other required participant, and the clinician.

(Org. Manual pg. 23)

Client Treatment Plan

- **Services which must be associated with an objective or objectives on the Client Treatment Plan:**
  - Mental Health Services
  - Targeted Case Management
  - Medication Support Services
  - Therapeutic Behavioral Services
  - Day Treatment Intensive Services
  - Day Rehabilitation Services
  - Crisis Residential Services
  - Transitional and Long Term Residential Services

- **Client Treatment Plans must be completed for all above treatment services and fall into 2 categories:**
  - **Annual (the anchor) -** Covers all services to be provided to a client.
  - **Update -** An addendum to the Annual, covering those objectives or services to be reviewed, added, modified, or deleted prior to the review deadline of the Annual Treatment Plan.

Client Treatment Plan

Annual Treatment Plan

- Used when completing the Initial or Annual Treatment Plan
- Covers **all services** to be provided to a client
- A client treatment plan is required in the clinical record after the completion of a new assessment and prior to providing treatment services.
- Minimally due **365 days** from the last Annual Treatment Plan for continuing clients.
  - Restarts the 365 day clock based on the "Plan Date"

Annual Treatment Plan Forms

- Paper form-Client Treatment Plan (MH 636)
- IBHIS – DMH Client Treatment Plan (select Annual as plan type)
- Contractors with EHR- data elements identified in the Org Manual)

(LACDMH Policy 104.09, section 4.4)

Client Treatment Plan

- **Annual Treatment Plan Elements**
  - Statement of long term goals in the client's words
  - Goals/treatment objectives related to the client's mental health needs and impairments
  - The objectives must be **S**pecific, **M**easurable/quantifiable, **A**chievable, **R**ealistic, **T**ime-bound (SMART)
  - Service modalities must be included with the intervention.
  - Detailed description of the mental health staff's intervention.
  - **Frequency and duration (if less than one year) of intervention**
  - Client and family involvement (LACDMH requirement)
  - Staff signature, discipline/title**, identification number(license/registration and certification number)** and date
  - Client/responsible adult signature
  - Evidence a copy of plan offered to client
  - Linguistic and interpretive needs

Client Treatment Plan

Update Client Treatment Plan

- Required for mandated review periods based on the type of program and as clinically appropriate.

- Does NOT reset the 365-day clock

- Frequency of Updates has not changed

Update Treatment Plan Forms

- Paper form-Client Treatment Plan Addendum (MH 636A)
- IBHIS- Client Treatment Plan Addendum (select Update as plan type)
- Contractor with Electronic Health Records- data elements identified in the Org Manual.

Client Treatment Plan

- **Elements of Client Treatment Plan Update**
  - See Org Manual for full requirements
  - For renewing, adding or modifying objective:
    - Must obtain all required signatures
    - Must offer client a copy of the Treatment Plan
  - For renewing, adding or modifying intervention:
    - Signature not required

(Org. Manual pg. 21)

Client Treatment Plan

- **Client Treatment Plan Forms**
  - Annual Treatment Plan
    - Paper form-Client Treatment Plan (MH 636)
    - IBHIS – DMH Client Treatment Plan (select Annual as plan type)
    - Contractors with EHR- data elements identified in the Org Manual)
  - Update Treatment Plan
    - Paper form-Client Treatment Plan Addendum (MH 636A)
    - IBHIS- Client Treatment Plan Addendum (select Update as plan type)
    - Contractor with Electronic Health Records- data elements identified in the Org Manual.

(Org Manual pgs.21-22)

Policy 104.09: Progress Notes

"A progress note must be completed for every service with and/or on behalf of the client, collaterals, or other agency staff regardless of reimbursement."

(LACDMH Policy 104.09, section 4.5)

Policy 104.09: Progress Notes

- **A progress note must also be:**
  - in the clinical record for each service prior to the submission of a claim per LAC-DMH Policy 104.08, Clinical Records Maintenance, Organization and Contents
  - completed with the frequency and required data elements identified in the Organizational Provider's Manual.
  - completed by the staff who provided the service (rendering provider) and acting within their scope of practice and in accord with the Guide to Procedure Codes.

(LACDMH Policy 104.09, section 4.5.1-4.5.3)

Progress Notes

- **Policy 104.09:**
  - Simply refers to the requirement for Progress Notes
- **Organizational Providers Manual:**
  - Operationalizes the requirement noted in 104.09
  - Describes the specific requirements, data elements and forms

PROGRESS NOTES

- **Progress Notes**
  - Purpose:
    - Provide a means of communication and continuity of care between all service delivery staff and provide evidence of the course of the client's illness and/or condition.
    - Describe how services provided reduced impairment, restored functioning or prevented significant deterioration in an important area of life functioning as described in the Client Treatment Plan.
  - Requirements:
    - Date of service
    - Procedure code (LACDMH Requirement)
    - 

Duration of service (Face-to-Face Time + Other Time)
      - **Applies to all services including groups and practitioners**
    - 

Language
    - For group, the number of total clients present
    - Relevant aspects of client care.

(Org. Manual, pg. 24)

PROGRESS NOTES

- Cont'd Progress Note Requirements
  - Client response to interventions
  - Client progress towards objectives
  - Location of the interventions
  - Referrals to community resources and other agencies (when appropriate)
  - Clinical Discharge Summary information
    - Complete face-to-face with client elements that must be included:
    - Brief treatment summary
    - Status update on the client's progress toward their treatment plan objectives
    - Referrals provided (if applicable)
    - Reason for termination of services
    - Follow-up plans (if applicable)
    - Other pertinent information such as whether medications were provided upon termination. Staff signature, discipline/title, identification number (if applicable) & date

Note: When more than one staff participates in the same service, only one signature is required (except for required co-signature situations), but names of any staff participating in the service must be included in the note with his/her intervention/contribution.

(Org Manual, pg. 24)

Chapter 2 (Mode 15)

SERVICE OVERVIEW & REIMBURSEMENT RULES

General Rules

Documentation Rules

Service Components NEW

TYPES OF SERVICES

Mental Health Services (MHS)

Medication Support Services (Meds or MSS)

Crisis Intervention (CI)

Targeted Case Management (TCM)

HOPE WELLNESS RECOVERY

LAC DMH
LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH

GENERAL SERVICE OVERVIEW & REIMBURSEMENT RULES

GUIDELINES FOR DOCUMENTATION

- **Frequency of Documentation**
  - For all Mode 15 services including Mental Health Services, Medication Support Services, Crisis Intervention & Targeted Case Management, every service contact must be documented on a separate progress note.
  - **NOTE**: For purpose of ***Targeted Case Management***, a single service contact may include multiple service activities (e.g. telephone calls) performed within same calendar day with the intention of meeting the same specific objective.

- **Claiming**
  - Exact number of minutes
  - Claim time must match actual time
  - Time claimed must not exceed time worked (literal interpretation)
  - Individual Service – directed toward or on behalf of 1 client.
  - **Group Service** - directed toward or on behalf of more than 1 client
    - Must be pro-rated to each client
  - For CLAIMING, when multiple staff are providing a service, the total time must be added together

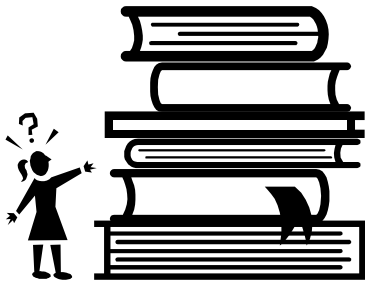
GENERAL SERVICE OVERVIEW & REIMBURSEMENT RULES

- **Site and Contact Requirements**
  - Services may be provided face-to-face, by telephone or through tele-psychiatry with the client or significant support persons.
  - Services may be provided anywhere in the community.

- **Documentation Rules**
  - Must clearly document benefit to client & medical necessity when services provided with or without direct client contact.
  - More than 1 staff providing service in a single contact should reflect that both staff were involved.
  - If two distinct services were provided, separate progress notes for each contact should be done (except plan development).

STATE PLAN AMENDMENTS

WHAT IS IT??



Service Components

- Service components apply to all Mode 15 types of services unless otherwise noted.
- Service components are defined in the State Plan Amendment and identify the reimbursable core Specialty Mental Health Services of the California Medicaid program.
- Service components are not procedure codes.
- While service components are always reimbursable, procedure codes may or may not be reimbursable.
- Each service component must address an identified mental health need.

(Org. Manual, pgs. 2-30)

Types of Service and Service Components

MENTAL HEALTH SERVICES (MHS)	
Service Components	Assessment
	Plan Development
	Therapy
	Rehabilitation
	Collateral

CRISIS INTERVENTION (CI)	
Service Components	Assessment
	Collateral
	Therapy
	Referral

MEDICATION SUPPORT SERVICES (MSS)	
Service Components	Evaluation of the Need for Medication
	Evaluation of Clinical Effectiveness & Side Effects of Medication
	Obtaining Informed Consent
	Medication Education
	Collateral
	Plan Development

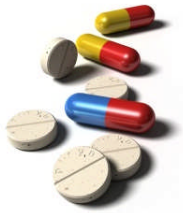
TARGETED CASE MANAGEMENT (TCM)	
Service Components	Assessment
	Plan Development
	Referral
	Monitoring & Follow-up

Service Components

- **Assessment-Mental Health Services -** Evaluation of client's current mental, emotional, or behavioral health status. Includes one or more of the following:
  - Mental status determination
  - Clinical history analysis
  - Analysis of current bio-psychosocial issues & history
  - Diagnosis
  - Psychological testing
- **Assessment - Targeted Case Management -** Determination of need for or continuation of Targeted Case Management (TCM) services in order to access any medical, educational, social or other services. TCM Assessment activities include:
  - Taking client history
  - Identifying client's needs
  - Reviewing medical, psychosocial, & other records
  - Gathering information from family members, medical providers, social workers, educators, etc.
  - Assessing support network availability, adequacy of living arrangements, financial status, employment status, & potential training needs.
  - Referral: Linkage to other needed services and supports.

Service Components

- **Collateral -** Services to client's significant support person(s) in order to provide support to the client in achieving their treatment plan goals. Includes 1 or more of the following which client may or may not be present for:
  - Consultation and/or training of significant support person(s) that would assist the client in increasing resiliency, recovery, or improving utilization of services
  - Consultation and training on mental illness and its impact on the client
  - Family counseling to improve client's functioning.
- **Evaluation of Clinical Effectiveness and Side Effects**



- **Evaluation of the Need for Medication**
- **Medication Education -** Includes the instruction of the use, risks, and benefits of and alternatives for medication

Service Components

Service Components Cont'd

- **Monitoring and Follow-Up**
- **Obtaining Informed Consent**
- **Plan Development -** Consists of treatment planning, approval of client treatment plans and/or monitoring client's progress.
- **Referral -** Linkage to other services and supports

Service Components

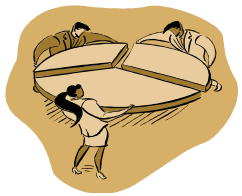
- **Rehabilitation -** Recovery or resiliency focused service activity identified to address mental health need in the client treatment plan.
  - Assists in restoring, improving, and/or preserving a client's functional, social, communication, or daily living skills
  - Aimed at enhancing self-sufficiency or self regulation in multiple life domains relevant to the developmental age and needs of the client.
  - May be provided to a client or a group of clients.

- **Therapy -** Therapeutic intervention that focuses primarily on symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments.
  - Therapeutic interventions include: application of cognitive, affective, verbal or nonverbal strategies based on the principles of development, wellness, adjustment to impairment, recovery and resiliency
  - Assists client in acquiring greater personal, interpersonal and community functioning
  - Assists to modify feelings, thought processes, conditions, attitudes or behaviors which are emotionally, intellectually, or socially ineffective.

(Org. Manual, pgs. 2-30)

Type of Services - Structure

Each section in the Organizational Manual describing Types of Services has the following structure:

- Definition 
- Service Components 
- Claiming 
- Medi-Cal Lockouts 
- Additional Information

TYPES OF SERVICES

- **Mental Health Services**
  - **Definition**

Mental Health Services are individual, group or family-based interventions that are designed to provide reduction of the client's mental disability, restore, and improve and preserve clients' individual and community functioning.

Improve client's ability to remain in the community consistent with the goals of recovery, resiliency, learning, development, independent living and enhanced self-sufficiency.

These are services that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive.

- **Service Components (State Plan Amendment) -** Mental Health Services include one or more of the following service components:
  - Assessment
  - Plan Development
  - Therapy
  - Rehabilitation
  - Collateral

(Org. Manual 2- 32)

TYPES OF SERVICES

Mental Health Services, cont.

- **Claiming -** Mental Health Services are claimed under Mode 15 (Outpatient).
  - **Service Function Codes**
    - 42 – Individual
    - 52 – Group
    - 34 – Psychological Testing
    - 10 – Collateral
    - 44 – Fee For Service MHS
    - 57 – Intensive Home Based Services

- **Medi-Cal Lockouts (**Applies to all Mental Health Services)
  - Not reimbursable on the same day as Crisis Residential Treatment Services, Psychiatric Inpatient Hospital Services, Psychiatric Health Facility except on the day of admission to any of these facilities.
  - Not reimbursable when provided by Day Rehabilitation or Day Treatment Intensive staff during the same time period that Day Rehabilitation or Day Treatment Intensive Services are being provided.
  - Not reimbursable when provided during the same time that Crisis Stabilization-Emergency Room or Urgent Care is provided.
  - May not allocate the same staff's time under Adult Residential and MHS at the same time
  - IHBS may not be provided in a group home (may be provided outside the Group Home setting to assist with transitioning)

TYPES OF SERVICES

Medication Support Services (MSS)

- **Definition** – One or more of the following: Prescribing, administering, dispensing, and monitoring drug interactions and contraindications of psychiatric medications or biologicals necessary to alleviate suffering and symptoms of mental illness. May also include re-evaluating for possible increase or decrease when indicated.
  - MSS must also be:
    - Individually tailored
    - Provided by a consistent provider with an established relationship with client

- **Service Components (State Plan Amendment)**
  - Evaluation of the Need for Medications
  - Evaluation of Clinical Effectiveness and Side Effects of Medication
  - Informed Consent
  - Medication Education
  - Collateral
  - Plan Development

(Org. Manual Ch. 2, pg.33)

TYPES OF SERVICES

Medication Support Services (MSS)

- **Claiming**
  - Service Function Code is 62 – Medication Support

- **Medi-Cal Lockouts** 
  - Not reimbursable on the same day as Psychiatric Inpatient Services or Psychiatric Health Facility Services except for the day of admission.

  - May not claim more than 4 hours per client per day.

TYPES OF SERVICES

Cont'd Medication Support Services

❖ Additional Information on Medical Support Services

- MSS provided as an adjunct to Residential or Day Treatment Intensive/Day Rehabilitation are billed separately from that service.
- When MSS provided to a client by a physician and nurse concurrently, time should be claimed for both.

NEW

  - If both staff providing the same service (e.g. medication education), 1 note written claiming time for both.
  - 2 staff provide different services during the contact (e.g. the physician writes a prescription and the nurse gives an injection), requires 2 notes with separate claims.
- Staff not eligible to claim MSS must write a separate note documenting service time as either Targeted Case Management or Mental Health Services, in accord with the service the staff provided.

NEW

- Medication specific Informed Consent (Outpatient Medication Review or court order) required when medications are prescribed, per LAC-DMH Policy 103.01 Standards for Prescribing and Furnishing Psychoactive Medications (State DHCS Contract Exhibit A Attachment I Section 11A; **CCR §851**).

(Org. Manual Ch. 2, pg. 33-34)

TYPES OF SERVICES

- **Crisis Intervention**
  - **Definition:**
    - An unplanned, expedited service, to or on behalf of a client to address a condition that requires more timely response than a regularly scheduled visit.
    - An emergency response service enabling a client to cope with a crisis, while assisting the client in regaining their status as a functioning community member.
  - **Service Components**

    - Assessment
    - Collateral
    - Therapy
    - Referral
  - **Claiming**
    - Service Function Code is 77 – Crisis Intervention

(Org. Manual, pages Ch. 2, pg. 34 - 35)

TYPES OF SERVICES

Crisis Intervention, cont.

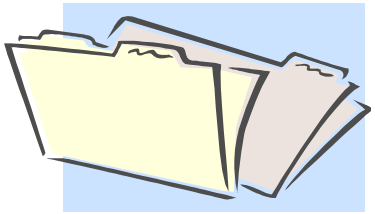
- **Medi-Cal Lockouts**
  - Not reimbursable on the same day as Crisis Residential Treatment Services, Psychiatric Health Facilities Services, Psychiatric Nursing Facility Services, or Psychiatric Inpatient Hospital Services except for the day of admission to any of these services.

- **Additional Information on Crisis Intervention**
  - May not claim more than 8 hours per client per day

(Org. Manual Ch. 2, pg.35)

TYPES OF SERVICES

- **Targeted Case Management (TCM)**



- **Definition**
  - Targeted Case Management means services that assist a client to access needed medical, alcohol and drug treatment, educational, social, prevocational, vocational, rehabilitative, or other community services
  - Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs to determine the need for establishment or continuation of targeted case management services to access medical, educational, social or other services.
- Development and periodic revision of a plan to address the medical, social, educational, and other services needed by the client.
- Referral and related activities
- Monitoring and Follow-up

(Org. Manual pgs. 2-35, 36)

TYPES OF SERVICES

Cont'd Targeted Case Management

- **Service Components (State Plan Amendment)**
  - Assessment
  - Plan Development
  - Referral
  - Monitoring and Follow-Up

- **Claiming**
  - Targeted Case Management includes the following Service Function Codes:
    - 04 – Targeted Case Management
    - 07 – Intensive Care Coordination (See DHCS Katie A Manual)

(Org. Manual pgs. 35-37)

TYPES OF SERVICES

- **Cont'd Targeted Case Management (TCM)**
  - **Medi-Cal Lockouts**
    - Non-Discharge Planning TCM is not reimbursable on days when Psychiatric Inpatient Hospital Services, PHF Services or Psychiatric Nursing Facility Services are reimbursed except for day of admission.
    - DC Planning TCM services are solely for purpose of coordinating placement upon discharge from the psychiatric inpatient hospital setting, PHF or psychiatric nursing facility.
      - TCM may be provided during the 30 calendar days immediately prior to day of discharge, for a maximum of 3 nonconsecutive periods of 30 calendar days or less, per continuous stay in the facility.
    - Not reimbursable when provided to a client in an Institution for Mental Diseases (IMD) except for clients who are under 21 years of age (22 in certain circumstances) or clients 65 years or older.

NOTE: Targeted Case Management **is reimbursable** during the same time Crisis Stabilization is provided. (No other specialty mental health service is reimbursable during the same period Crisis Stabilization is reimbursed.) [CCR §1840.368 (b)]

(Org. Manual, pg. 36)

DISCUSSION – BILLABLE ACTIVITIES

Important questions to ask, when trying to determine whether a service is a billable:

- What service component is being provided to the client?
- Is it an administrative activity?
- Is this something you would normally do during the course of your treatment had it not been requested by an agency (e.g. court, DCFS)?

*Note: Completing SSI Applications or report writing are not billable services.

Questions

Presented by:

Program Support Bureau

Quality Assurance Division

QA@dmh.lacounty.gov

TYPES OF SERVICES & SERVICE COMPONENTS

Each Type of Service has associated Service Components (activities) which are reimbursable under that Type of Service.

MENTAL HEALTH SERVICES (MHS) (*Individual, group or family-based interventions designed to provide reduction of client's mental/emotional disability, improve/preserve functioning and remain in the community)*	
Service Components	Assessment
	Plan Development
	Therapy
	Rehabilitation
	Collateral

CRISIS INTERVENTION (CI) *(unplanned, expedited services, to or on behalf of client to address condition that requires more timely respond than a regular visit)*	
Service Components	Assessment
	Collateral
	Therapy
	Referral

MEDICATION SUPPORT SERVICES (MSS) (Prescribing, administering, dispensing & monitoring drug interactions and contraindications of psychiatric medications necessary to alleviate symptoms of mental illness; assessing appropriateness of reducing medication usage*)*	
Service Components	Evaluation of the need for medication
	Evaluation of clinical effectiveness and side effects of medication
	Obtaining informed consent
	Medication education
	Collateral
	Plan Development

TARGETED CASE MANAGEMENT (TCM) (*Assist in accessing needed medical, alcohol/drug treatment, educational, social, vocational, rehab or other community services*)	
Service Components	Assessment
	Plan Development
	Referral
	Monitoring and Follow-up

Service Component Definitions (See Organizational Providers Manual Pages 29 & 30 for complete definitions)

- Assessment (for MHS) – Evaluation of client's current mental, emotional or behavioral status
- Assessment (for TCM) – Evaluation of need for assistance in accessing medical, educational, social or other services
- Collateral – Services to client's significant support person(s) in effort to support client in achieving their goals
- Evaluation of Clinical Effectiveness and Side Effects
- Evaluation of Need for Medication
- Medication Education – Includes the instruction of the use, risks, and benefits of and alternatives for medications
- Monitoring Follow Up
- Obtain Informed Consent
- Plan Development – Development of client treatment plans, approval of client treatment plans & monitoring client's progress.
- Referral –Linkage to other needed services and supports
- Rehabilitation – Assistance in restoring, improving and/or preserving skills needed to address mental health needs
- Therapy –Therapeutic intervention primarily focused on symptom reduction & restoration of functioning; includes application

WHAT's NEW?

Policy, Definition, Term and Form Changes Related to Clinical Documentation

POLICY, DEFINITION & TERM CHANGES

OLD	STATUS	NEW	DEFINITIONS & COMMENTS
Client Episode	Replaced	Client Clinical Record	• With IBHIS, no longer closing episodes outpatient episodes • Documentation requirements refer to what is in a single clinical record (whether at the provider or LE level)
Authorized Mental Health Discipline (AMHD) - *Eligible disciplines that may complete assessments and provide direction regarding care of clients in the LAC-DMH System of Care*	Revised	AMHD - Eligible disciplines that may provide direction regarding care of clients in the LAC-DMH System of Care	• Refer to **Guide to Procedure Codes** for list of disciplines who can complete assessments
Opening an Episode – An assessment is required for all open episodes	Replaced	Newly Active Client - An assessment is required for all newly active clients	• Newly Active Client – ✓ New Client - New client requiring the opening of a new clinical record **Or** ✓ Returning Client - Existing client returning for services after 180+ days of inactivity **Or** ✓ Returning Client - Existing client returning for services due to a new or resurfacing presenting problem after the termination of services (Policy 202.30)
A CCCP is required for all services after 60 days except crisis intervention and one time types of services	Replaced	A Client Treatment Plan must be completed prior to providing treatment services and, minimally, within 60 days of initiation of services excluding crisis intervention	• Treatment Services - Services addressing client mental health concerns that are not primarily for the purpose of: ✓ Assessment, ✓ Plan development, ✓ Crisis intervention, or, ✓ During the first 60 days for new/returning clients, linkage to other mental health programs
A CCCP is required the month prior to the cycle date.	Replaced	For "active" clients, an Annual Client Treatment Plan must be completed with client at least once every 365 days.	• Due minimally 365 days from the start date of the most recent Annual Client Treatment Plan • If the client is unavailable, must be completed at the point of next service with the client. • An update to the Annual Client Treatment Plan must be done upon mandated review periods for certain types of services and as clinically appropriate
An annual assessment must be completed for every client	Frequency Changed	For active clients an assessment is minimally required every 3 years	• Assessment used to be required annually, now it's tri-annual (every 3 years) based off the most recent new client, returning client or continuous client assessment start date
Single Fixed Point of Responsibility	Replaced (for DO ONLY)	Primary Program of Service	• Similar to SFPR concept except only includes the Directly-Operated programs. • Ensures Client Treatment Plans are completed • Coordinates services within DO programs

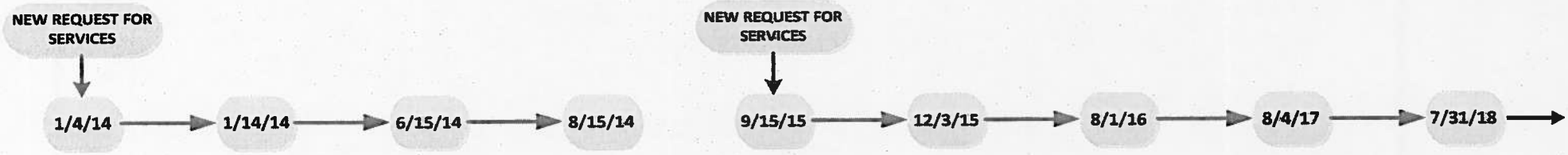
WHAT's NEW?

Policy, Definition, Term and Form Changes Related to Clinical Documentation

FORM CHANGES

OLD	STATUS	NEW	REQUIREMENTS	COMMENTS
Adult Initial Assessment (MH 532)	Renamed & Revised	Adult Full Assessment (MH 532)	• For <u>new clients</u> must be completed within 60 days of the initiation of any services.	
Child/Adolescent Initial Assessment (MH 533)	Renamed & Revised	Child/Adolescent Full Assessment (MH 533)		
Adult Short Assessment (MH 678)	Discontinued	None		• Recent State Chart Review findings indicated that the Short Assessment did not contain documentation sufficient to support the inclusion of all required assessment elements.
Child/Adolescent Assessment Short Format (MH 536)	Discontinued	None		
Annual Assessment Update (MH 637)	Discontinued & Replaced	Adult Re-Assessment (MH 713)	• Assessments for returning clients must be completed within 60 days of the initiation of services • Assessments for continuous client must be completed minimally every 3 years (Tri-Annual Assessment)	• Completion of a Full Assessment or Re-Assessment resets 3 year clock for the continuous client assessment.
		Child Re-Assessment (MH 714)		
Client Care Coordination Plan (MH 636)	Renamed & Revised	Client Treatment Plan (MH 636)	• Must be completed in each Clinical Record.	• Outcomes Section on Client Treatment Plan no longer exists • Coordination Plan Page no longer exists. Staff and Providers must still coordinate client's care (see Clinical Records Bulletin 14-01 for details) • Directly Operated providers using same Clinical Record share Client Treatment Plan.
Discharge Summary (MH 517)	Discontinued	Documentation in Progress Note	• When a client is terminated per DMH Policy 202.30, there must be documentation of key elements in the progress notes: ✓ A brief treatment summary ✓ A status update on the client's progress toward their tx plan objectives ✓ Referrals provided (if applicable) ✓ Reason for termination of services ✓ Follow up plans (if applicable) ✓ Other pertinent information.	

DOCUMENTATION EXAMPLE SCENARIO



INDIVIDUAL PRESENTS FOR SERVICES	TREATMENT PLANNING	MEDICATION EVALUATION	TERMINATE SERVICES	CLIENT RETURNS FOR SERVICES	CLIENT TRANSFERS TO ANOTHER PROGRAM*	ANNUAL TREATMENT PLANNING	ANNUAL TREATMENT PLANNING	TRI ANNUAL ASSESSMENT & TREATMENT PLANNING
✓ Create Clinical Record ✓ Complete New Client Assessment using **Full Assessment**	✓ Complete **Annual Client Treatment Plan**	✓ Add Medication Objective/Interventions to the Client Treatment Plan (**Update Client Treatment Plan**)	✓ Complete Progress Note with discharge data elements	✓ Complete Returning Client Assessment using **Re-Assessment** ✓ Complete **Annual Client Treatment Plan**	✓ Complete **Assessment Addendum** to document change in sxs/impairments ✓ Complete **Update Client Treatment Plan** to document new interventions	✓ Complete **Annual Client Treatment Plan**	✓ Complete **Annual Client Treatment Plan**	✓ Complete Continuous Client Assessment using **Re-Assessment** ✓ Complete **Annual Client Treatment Plan**
ASSESSMENT Start Date: 1/4/14 Next Due date: 1/4/17				ASSESSMENT Start Date: 9/15/15 Next Due date: 9/15/18	ASSESSMENT Start Date: 12/3/15 Next Due date: 9/15/18			ASSESSMENT Start Date: 7/31/18 Next Due date: 7/31/21
	TREATMENT PLAN Start Date: 1/14/14 Next Due date: 1/14/15	TREATMENT PLAN Start Date: 6/15/14 Next Due date: 1/14/15		TREATMENT PLAN Start Date: 9/15/15 Next Due date: 9/15/16	TREATMENT PLAN Start Date: 12/3/15 Next Due date: 9/15/16	TREATMENT PLAN Start Date: 8/1/16 Next Due date: 8/1/17	TREATMENT PLAN Start Date: 8/4/17 Next Due date: 8/4/18	TREATMENT PLAN Start Date: 7/31/18 Next Due date: 7/31/19

*Program must be using the same Clinical Record.

NOTE: The name of paper forms are listed. See the Organizational Provider's Manual for required data elements if using an EHRS.